TABLE OF CONTENTS

Page Numbers

LEGISLATIVE REPORT

Executive Summary

This report presents the Department of Mental Health's first five months of administration and implementation of pilot services at the local level required by Assembly Bill (AB) 34 (Steinberg, Chapter 617, Statutes of 1999).

With the assistance and support of Governor Gray Davis and the Legislature, $10 million was provided in the state budget for pilot programs directed at serving homeless persons, parolees, and probationers who are seriously and persistently mentally ill. The bill required that three selected counties implement pilot programs which use intensive, integrated community outreach and a variety of services to target the individual needs of those persons who are either homeless, at risk of homelessness, or at risk of incarceration. The bill required that the Department of Mental Health develop a reporting methodology for data collection and perform extensive monitoring and evaluation of the pilots.

The Department found that the effect of the intensive, integrated outreach and community-based services was to enable the target population to reduce symptoms that impaired their ability to live independently, work, maintain community supports, care for their children, remain healthy, and avoid crime. This report describes the processes used and the identification of approaches to services and strategies that were helpful in identifying and engaging clients and that could serve as guidelines for future projects. Key among these approaches appears to be a very close collaboration at the local level among core service providers, including mental health services, law enforcement, veterans services agencies, and other community agencies.

The tables in Appendix 1 present data collected from the pilot programs beginning November 1, 1999. These data, together with the results of the other monitoring and evaluation activities, have led the Department to conclude that these pilots have been successful. Moreover, in some instances, the level of success has important implications for the future of adult systems of care implementation. The collected data from the pilot programs show that slightly more than half of all enrollments were accepted by ethnic minorities and that fewer than 15% of eligible clients refused enrollment in the programs. Additionally, inpatient hospitalizations have been reduced for enrollees (even though pent-up demand might have exerted an opposite effect), and incarcerations and other contacts with law enforcement have dropped since enrollment. The ability to maintain housing once enrolled also appears to be improving, and the majority of enrollees would like to work. However, because pilots address housing and health needs first so that clients have some stability upon which to begin employment, adequate time to achieve meaningful employment outcomes has been limited.

One finding in the report regarding fiscal factors is that that the variability of housing costs in each county significantly influences the budgeted cost per client. Additionally, costs are generally higher when programs include the capacity to respond quickly to housing needs. The amount of outreach required can also have a significant influence on cost per enrollee. Further monitoring and study are necessary to determine what influence the ability to obtain third party reimbursement and benefits for enrollees may have on costs in the future.

Based on its findings, the Department makes the following recommendations.

1. AB 34 pilots should be considered for expansion and replication in other counties, with adequate start-up time to organize service elements appropriate to this service population.
2. Counties currently receiving these funds and counties funded in the future should continue to meet existing contractual and data reporting requirements.
3. These programs should be funded on a continual basis subject to satisfactory performance as determined by the Department. Department staff for these programs should be funded on a permanent basis.
4. The Department should continue monitoring all programs to assure program integrity and identify areas for technical assistance and/or consultation for counties planning new services.
5. The Department should explore the means to make additional technical assistance, planning, and training available to counties requiring support in implementing and/or operating these new services.
6. The Advisory Committee should continue to assist the Department in the refinement of selection and evaluative criteria.
7. Comprehensive independent evaluation of results can give critical information regarding programs successes and program planning.

DATA ANALYSIS AND OBSERVATIONS

Data Summary

The tables in Appendix 1 present data collected from the pilot programs beginning November 1, 1999, and are summarized below.

- Fewer than 15% of eligible clients refused enrollment in the programs.
- Clients are mostly men (62.3%).
- 43.3% are Caucasian, 36.7% are African-American, 12.3% are Hispanic, and 1% are Asian.
- Clients are mostly between 22 to 59 years of age (89.8%).
- 2.1% of all enrollees are over the age of 60.
- 4.6% of enrollees are between the ages of 18 to 21.
- The percentage of clients leaving the program is less than 4%.

The outcomes presented here for post-enrollment have been annualized, based on the first four months of data collection.

- The percentage of enrollees hospitalized since enrollment has dropped 64.2%.
- The number of days of incarceration dropped 73%.
- The number of days spent homeless dropped 58.92%.

The following table summarizes statewide data for three key factors by comparing data reported for the twelve months before services began to the data collected since.

Statewide Data at a Glance (Annualized)

	12 months Prior to Enrollment	Since Enrollment (Annualized)
Number of Days Homeless	159,495	65,523
Number of Days Incarcerated	41,129	11, 007
Number of Days Hospitalized	10,213	3,654

Issue Statement

Governor Gray Davis provided $10 million in the state budget for 1999-2000 for expanded community mental health services to fund Adult System of Care programs directed particularly at serving homeless persons, parolees, and probationers with serious mental illness. With the assistance and support of the Legislature, new legislation, Chapter 617, Statutes of 1999 (AB 34, Steinberg), provides for pilot programs which use an integrated services approach and are targeted to specific individual needs in up to three counties. The bill required the Department of Mental Health to select counties in which to implement pilot programs, develop and perform an extensive monitoring and evaluation of the pilots, establish an advisory committee to assist in developing selection criteria and outcome measures for future programs, and report the results of the pilot programs and recommendations to the Legislature by May 1, 2000. This report is in response to that requirement.

Background

This bill and related efforts represent a new broad interest and support in addressing community mental health needs which have largely gone unmet for those persons whose illness leads them to being homeless or incarcerated, often repeatedly so, yet who otherwise either avoid contact with mental health services, for whom appropriate services remain unavailable, or who are without Medi-Cal benefits and/or do not meet Medi-Cal medical necessity. The consequences of this gap in service contribute to a problem of significant proportions. It has been estimated that there are over 50,000 homeless Californians with severe mental illness, of whom 10,000 to 20,000 are veterans. Many of these persons who do not have access to needed mental health services have contacts with the criminal justice system for crimes like vagrancy, littering, disturbing the peace, and for other citations or arrests. This population also experiences high cost inpatient hospitalizations because their mental health needs are addressed only when they reach crisis levels. Thus, hospitalizations are for longer periods of time and, since no resources are available for these individuals upon their release, the likelihood of relapse is higher. In addition, the Department of Corrections is expending approximately $400 million annually for the incarceration and treatment of people suffering from severe mental illness. The Department of Corrections and the criminal justice system house a combined total of approximately 4,500 persons in the state mental hospitals, for an additional annual state cost of over $300 million.

The local assistance funds for AB 34 have expanded on existing programs that were based on earlier models that demonstrated success in providing integrated services. These earlier efforts consisted of three large pilots for adult systems of care that were established in 1989 pursuant to earlier legislation (Chapter 982, Statutes of 1988) to test the success of integrated services across all human

service needs in the recovery and rehabilitation of adults with serious mental illness. An extensive evaluation conducted by an independent evaluator concluded after three years of service that the integrated approach to serving this population was successful, and on some measures such as employment and housing, dramatically so. Subsequent data taken eight years after the inception of these pilots further confirmed the continued success in at least one of the original sites. The pilots are no longer operated on a project basis and have become programs within each host county's adult systems of care. One has served as a mini institute for the replication of this program model and the use of client-directed services. During this period, a few counties had the opportunity to reconfigure services for their adult population and chose to implement integrated services modeled after these programs. Despite the likelihood of eventual cost effectiveness, most counties cannot access or divert the large sum of funds required to initiate this service model and train staff in its operation. However, these models served as part of the foundation for Governor Davis' and Assembly Member Steinberg's interest in taking a new approach to adult mental health services.

The pilot programs that are the subject of AB 34 are being used to provide comprehensive services to adults who have severe mental illness and who are homeless, at risk of becoming homeless, recently released from a county jail or the state prison, or others who are untreated, unstable, and at significant risk of incarceration or homelessness unless treatment is provided to them. The bill provides funds for the counties to establish outreach programs and mental health services along with related medications, substance abuse services, supportive housing or other housing assistance, vocational rehabilitation and other non-medical programs necessary to stabilize this population. The goal is to get them off the street and into permanent housing, into treatment and recovery, or to provide access to veterans' services that also provide for treatment and recovery. To the extent that these services are effective in reducing recidivism, both in inpatient hospitalization and incarceration, significant cost avoidance is realized at both the state and county level.

Objectives

This legislation adds several objectives to California's adult system of care serving adults with serious mental illness. Objectives for the development and implementation of programs to serve as the pilots for this legislation now include the following:

1. Develop programs to demonstrate the effectiveness of these pilots in response to the needs of the target population.
2. Promote the development of integrated outreach and services to enable the target population to reduce symptoms that impair their ability to live independently, work, maintain community supports, care for their children, remain healthy, and avoid crime.

3. Maintain funding for existing adult system of care programs that meet contractual goals as models and technical assistance resources for other counties.
4. Provide funds for counties to establish outreach programs and related services to the target population.
5. Identify standards to ensure that members of the target population are identified and that appropriate services are provided.
6. Establish a methodology for awarding future adult system of care grants.
7. Establish an advisory committee to assist in the development of award criteria and reporting requirements.
8. Establish an evaluation and reporting methodology for programs funded by adult systems of care.

Implementation Approach and Study Methodology

Selection Process

As required by statute, selection of counties for the initial grants was based on the availability of existing programs able to provide integrated services with extensive experience in serving similar target populations. Typically, these programs employ psychosocial rehabilitation and recovery principles and consist of: outreach for identification, assessment, and diagnosis of target clients; mental health treatment including provision of medications and medication education and monitoring; and service coordination to assure development of a plan with access to services that meet the client's expressed needs. Factors included in these considerations were the counties' working agreements with other providers such as law enforcement, alcohol and drug services, medical and dental health practitioners, rehabilitation services, and housing providers.

Allocation of Funds and Conditions for Allocation

Three counties were awarded allocations under the AB 34 pilot program: Los Angeles County received $4.8 million, Stanislaus County received $1.9 million and Sacramento County received $2.8 million. Conditions of the allocations require that the counties ensure that all funds provided are used to provide new service in integrated adult service programs and ensure that none of those funds are used to supplant existing services to severely mentally ill adults. Each county was required to submit a work plan for approval by the state. The work plans contain the amount of contract funds to be expended and for what period, the total number of unduplicated clients to be enrolled, the maximum number of clients to be served at any one time, the outreach methods to be used, and the portion of funds used for that purpose. The plans also contain the anticipated number of contacts with people who are homeless or at risk of homelessness

and the number of those who have severe mental illness and who are likely to be successfully enrolled in services, as well as the screening process employed to identify clients for continuing services. Assurances also were required that state and federal requirements regarding tracking of funds would be met and that patient records would be maintained in such a manner as to protect privacy and confidentiality, as required under federal and state law.

Hiring of Department Staff

Hiring of limited term staff in the Department for administering this program coincided with the implementation of the projects. Two Staff Mental Health Specialists, one Associate Mental Health Specialist, and one Office Technician have been hired. Recruitment efforts for another Associate Mental Health Specialist are underway.

Advisory Committee

In accordance with Chapter 617, an Advisory Committee has been appointed and convened. The membership includes representatives from each of the groups specified in law. This committee has met approximately every six weeks since November 1, 1999. The Department has prepared a monthly update on the implementation of the projects and furnished this to the committee members. See Appendix 4 for a roster of committee membership.

Establishing Data Workgroup and Reporting Mechanisms

A data collection workgroup consisting of staff from the three demonstration counties and the Department was established to develop a reporting methodology that would meet the legislative requirements. The three demonstration counties report monthly progress toward enrollment. The remaining data, as described below, are reported on a monthly basis.

Study Methodology

The data collection workgroup designed a set of tables to display data required for this report. The data are divided into two groups, 1) data collected at enrollment (service entry) that provide information about the client for the twelve months prior to enrollment, and 2) data collected subsequent to enrollment that track outcomes after service in these pilot programs is initiated. In addition to age and ethnicity, the baseline data for the twelve months prior to enrollment for each new service member include:

- the number of hospitalizations;
- the number of members with co-occurring substance abuse disorders;
- the number of other service contacts with local mental health plan services;

- the number of contacts with local law enforcement other than arrests or incarcerations;
- the number of arrests;
- the number of days incarcerated;
- the number of days spent homeless;
- the number of days employed full time and part time, and
- whether the member had been on probation or parole.

Ongoing data include:

- the number of enrolled persons being served;
- the number of enrolled persons who are able to maintain housing;
- the number of enrolled persons who receive extensive community mental health services;
- the number of enrolled persons on probation, parole, or with other contacts with law enforcement and the number of contacts, arrests and days incarcerated;
- the number of enrolled persons hospitalized and the number of days hospitalized;
- the number of enrolled persons employed full time and part time, competitively employed, in supported employment, and in vocational rehabilitation;
- the number of persons disenrolled;
- the number of persons referred to and served by county mental health plan services; and
- the number of members newly qualified for third party payments.

In Appendix 1, data reported since November, 1999, are displayed. In addition to these data, Department staff obtained information through a series of program site visits, client and staff interviews, and exchange of information pertinent to program implementation, as indicated below.

Onsite Monitoring and Review of Pilot Projects

Department staff have visited project sites at the rate of approximately two a week since early January. The purpose of the visits has been to oversee implementation, provide technical assistance, and become familiar with the operation of the projects. The visits include observing treatment activities, interviewing clients, meeting with local staff, and accompanying outreach teams. The Department has written a series of progress reports that include summary notes of several site visits.

Development of Program Standards

As part of their site visits, Department staff have been identifying approaches to services and strategies for identifying and engaging clients that seem to be most effective and could serve as guidelines to be shared with other projects now and

in the future. Local staff from particularly effective projects have been invited to do presentations at the Advisory Committee meetings. It is expected that future efforts of the Advisory Committee will be directed at developing outcome measures and that part of this effort will also contribute to developing program standards.

Findings

The tables in Appendix 1 present the data collected from the pilot programs beginning November 1, 1999. Inspection of these data and other sources of information mentioned above lead the Department to conclude that these pilots have been successful. For some of the measures discussed below, the high level of success has important implications for the future of adult systems of care programs.

Tables 1, 2, and 3 display demographic information about gender, ethnicity, and age respectively for each of the pilot programs, grouped by county. In each of these tables, the first column of data contains the number of clients the county contracted to enroll and serve, and the second column contains the actual number of client enrollments to date. Among these data, it is worth noting that more than half of all enrollments were accepted by ethnic minorities. Thus, to the extent that these pilots continue to be successful, their applicability to minority populations appears promising.

Table 4 contains fiscal information about the budgeted cost per enrollee and the level of outreach effort expended to achieve current enrollment levels. A few of the providers listed do not show a budgeted cost per enrollee since their effort was directed wholly at outreach or administration and not for enrollment and services. Even though this target population had earlier been considered reluctant to accept services, fewer than 15% of eligible clients refused enrollment in these programs.

Table 5 contains baseline information collected about enrollees for the twelve months prior to service enrollment. As can be seen, among these clients there existed significant substance abuse, unemployment, and lack of a third party payor of services. And, while hospitalizations were reported for some clients, most had no recent contact with any mental health service. The last column displays the number of clients awaiting enrollment. Typically, these are clients who have been identified for enrollment while still incarcerated and for whom enrollment has been reserved so that they may begin services upon release.

Table 6 contains information about hospitalizations prior to and since the client's enrollment. When adjusting the partial year information for purposes of comparison to baseline information, hospitalization days are lower despite the opposite effect pent up demand might have exerted.

Tables 7 and 8 contain information about incarcerations and other contacts with law enforcement, all of which have fallen significantly since enrollment. Thus, the close cooperation with local law enforcement that is typical of these pilots should be given a high priority when replicating or expanding these services.

Table 9 contains information about the client's living situation prior to and since enrollment. Again, when adjusted for partial year information, the number of homeless days appears to have been reduced significantly.

Table 10 contains information about employment. So far, results appear to be limited; yet, pilots report a majority of enrollees would like to work. Pilots also report addressing housing and health needs first so that clients have some stability upon which to begin employment. Moreover, the limited period during which these pilot programs have operated constrains the amount of time during which employment success can be measured and subsequently reported. This is an important area and should continue to be studied to determine if these programs can achieve a level of success that is conclusive.

Table 11 contains additional information about third party payor status and disenrollments. All clients are encouraged and assisted to apply for federal benefits, i.e. Supplemental Security Income (SSI), Social Security Disability, and/or Veterans Administration benefits. However, because there is a three to four month lag between application for SSI benefits and federal approval, it is not expected that pilots would yet report a significant number of enrollees for whom these benefits have been obtained. Clients overwhelmingly continue to accept services once they are enrolled, based on the limited number of disenrollments.

Program/Fiscal Impact

Results obtained so far indicate that this model has substantial implications for improved services and for cost savings/avoidance associated with this population at the local level. Integrated services offer an expanded array of service components, such as housing, employment, life skills coaching, and social support in addition to treatment. In addition to these program improvements, the model offers the capacity to respond quickly with an extensive service package suited to individual client needs and preferences. Clients immediately engage with provider efforts that they can easily recognize are directly related to their own priorities. They also benefit from immediate efforts to establish a relationship of trust and respect that they value as part of their own efforts towards recovery. The goal shared by the staff and each client is not just maintenance in a community setting, but continual improvement enabled by the client's own abilities to manage recovery.

Without existing providers skilled in the operation of this service model, it is reasonable to expect a substantial amount of startup activity before these services can be offered at the local level. Two program elements that merit

particular attention during startup efforts are outreach and collaboration with local law enforcement. Outreach teams composed of mental health staff, law enforcement, and veterans service representatives appear to constitute a necessary core for successful outreach with potential clients. In addition, a well-coordinated effort between the outreach/service teams and local law enforcement is a critical element of service design.

Important fiscal impacts also appear to result from this service model. Even though it is still too early to make substantive claims regarding the long term effect of these services upon the use of hospital services, the law enforcement costs formerly associated with this population have dropped significantly. With daily jail costs ranging from $50 to $60 for the general jail population, and a range of $300 to over $400 for the medical/psychiatric jail population, any substantial reduction in the number of jail days produces an important local savings and/or cost avoidance.

The budgeted cost per client differs widely among the pilots. Several factors are known to contribute to this, but more experience is needed to fully understand annual cost per client as related to initial vs. long term outreach costs, local housing costs, program expenses for young or older adults as compared to adults, and the potential for third party reimbursement of program expenses, including reimbursements not directly related to medical necessity.

The factor most influencing the budgeted cost per client is the degree to which services are geared to provide housing for homeless clients. Having the capacity to respond to an individual's housing needs requires a considerable amount of program effort to pursue housing options, develop adequate capacity, and enable clients to acquire and maintain housing. Other factors known to have impacted the cost per client are the amount of outreach efforts required in the course of enrolling clients and the amount of startup costs required to increase the service capacity among providers. Sacramento County began providing services at an average budgeted cost of $14,000 per client. This may have come close to a realistic balance between an effective service array that includes permanent housing and maximizing the number of clients being served under local conditions, as far as Department staff can determine based upon monitoring first year program efforts in participating counties. Further monitoring is necessary to determine to what extent this cost may be offset by additional third party reimbursement, as mentioned above.

Recommendations

1. AB 34 pilots should be considered for expansion and replication in other counties, with adequate start-up time to organize service elements appropriate to this service population.
2. Counties currently receiving these funds and counties funded in the future should continue to meet existing contractual and data reporting requirements.

3. These programs should be funded on a continual basis subject to satisfactory performance as determined by the Department. Department staff for these programs should be funded on a permanent basis.
4. The Department should continue monitoring all programs to assure program integrity and identify areas for technical assistance and/or consultation for counties planning new services.
5. The Department should explore the means to make additional technical assistance, planning, and training available to counties requiring support in implementing and/or operating these new services.
6. The Advisory Committee should continue to assist the Department in the refinement of selection and evaluative criteria.
7. Comprehensive independent evaluation of results can give critical information regarding programs successes and program planning.

Appendix 1

Data Tables

Appendix 2

Program Observations

Department staff have made a substantial number of observations of early program implementation that may be useful in the successful replication of this program model. Some of these factors consistently appear among providers that demonstrate success in various aspects of program implementation. Though the following list is not complete and is subject to further refinement as the Department and programs gain more experience, it may contain characteristics which might be useful for future program expansion or be considered for the eventual development of program standards.

1. Development of an integrated service system that is recovery-based is key for persons with serious and persistent mental illness which stabilizes and normalizes the lives of those persons who have been identified and served by the program.
2. Reduced recidivism for those who have previously been incarcerated, providing significant cost avoidance both at the state and county level, should encourage and guide local program development.
3. These services should increase incentives for services to persons in need of mental health services who do not have Medi-Cal coverage, especially those who are homeless.
4. These services should increase permanent housing options and thereby decrease the number of homeless adults in the community and reduce related complaints from residents and merchants.
5. These services should decrease the likelihood that severely and persistently mentally ill persons would commit or be victimized by crime.
6. These services should reduce the time and assets that local law enforcement would need to dedicate to persons with mental illness.
7. Enhanced opportunities for persons with severe and persistent mental illness to find and maintain productive employment are very important to the viability and eventual sustainability of this service model.
8. Reduced inpatient hospitalizations by providing comprehensive and coordinated systems of care that promote collaboration among local service agencies should encourage and guide local development of these services.

Appendix 3

Vignettes of Client Experiences

The following anecdotes were either compiled by Department of Mental Health staff or sent by staff from various contract providers under the AB 34 program. For reasons of confidentiality, names have been changed. All vignettes represent a real person and their experiences after being enrolled as clients.

Sacramento County

1. When he was first located, Ken, a Caucasian male, appeared to be approximately 50 years old. He was homeless, poorly dressed, with poor hygiene and appeared to be intoxicated. His insight and judgement were assessed at poor to fair level. Although he was cooperative during the interview, he revealed a long history of mental illness with a diagnosis of Bipolar Disorder. Apparently, he was an AB 34 client who had required hospitalization at SCMHTC a month ago. Upon his discharge, he was unable to figure out how to get back to his place of residence and found it difficult to re-establish contact with his program or to make a follow up visit with a psychiatrist. Therefore, he went back to the encampment he had been staying at prior to his enrollment. As a result, he had no medication. When the outreach team found him, he reported that he had been self-medicating with his own medication (alcohol).

   When it was suggested that he could return to the AB 34 program, he was willing and anxious to participate once again. Therefore, the outreach team transported him to Northgate Point, where he met with his personal services coordinator in order to re-initiate services. The outreach team then showed Ken an hotel (SRO), where he would be able to stay once he detoxified from alcohol. This increased his motivation. He was very happy to find out that he would be staying there and expressed the thought that it was the nicest place he had seen in a while. Finally the team transported him for drug & alcohol counseling services. In addition, a psychiatrist would assess him for his psychiatric medication within 24 hours.

2. Bill is a 44-year-old Caucasian male. He experiences short-term memory loss, recurring auditory hallucinations, paranoia and substance abuse. He has a 14-year history of homelessness, with 180 days of homelessness in the past 12 months. He has relied primarily on panhandling for income. Bill is blind in the left eye and has limited insight into his own illness. The Department of Rehabilitation referred him to Turning Point, a Sacramento County contract provider on November 11, 1999 and he was enrolled in the homeless intervention program. His clothing was dirty and his hygiene was poor. He was diagnosed with major depression, recurrent, severe,

and with psychotic features. A review of files showed no history with the mental health system prior to his enrollment. He was on general assistance at the time of admission.

Upon enrollment, Bill was housed at a local motel and a personal services coordinator was assigned. He immediately saw a psychiatrist and was prescribed an anti-psychotic medication, as he reported sleep disturbances, minor auditory hallucinations, and the feeling that he was "being followed."

Shortly after entering the program, he reported his change of status to his general assistance worker and his benefits were reduced because his housing and food were being paid for. He has since applied for Supplemental Security Income on the basis of his disability and his case is under consideration.

In January, Bill signed up for career exploration, a program within Turning Point that allows members to work at the agency in a supported employment capacity. Bill began working in the office under the supervision of the administrative support staff, where he demonstrated an ability to take direction and to work independently.

In late January, Bill began exploring stable community living options, and by mid-February, with public housing financial support, he moved to a single room occupancy hotel. Also at that time he began working as an on-call employee for the HIP program, and his number of hours of work per week increased. Bill also expressed a desire to work with other members at the hotel.

Bill continues to live at the single room occupancy hotel and is looking forward to getting his own apartment. In addition, Bill is working a few nights a week with other members at the hotel and a few days per week as administrative support at the HIP office. He no longer reports feeling that he is "being followed", and the auditory hallucinations have all but disappeared. His short-term memory has improved and his insight into his illness has increased.

Los Angeles County

Irene is an enrollee from Los Angeles County. She had been in a state hospital for two years. During that period she was in restraints the majority of the time due to a history of severe self-mutilating behaviors. She walked around with leg restraints while in the hospital. After attacking a state hospital staff member, charges were pressed, and she was transferred to the psychiatric hospital inside the Los Angeles County Jail Forensic Inpatient Program. She was referred to the AB 34 program by her public defender. Contract program staff met with Irene at

court, evaluated her extensively in jail, including a visit by the program's psychiatrist. Irene has been out of jail approximately 9 weeks and is living in a board and care home, attending group activities regularly, and has returned to school part-time. She is medication compliant, and most importantly, her self-mutilating behavior has virtually disappeared.

Stanislaus County

Stanislaus County, through AB 34, has funded the Visions Young Adult Achievement Program of Stanislaus County. This program is for transitional age youth with mental health diagnoses who are no longer eligible for children's services and provides them with a complete range of services. Primary goals in the first month following intake are to meet basic needs such as housing, utilities, accessing services such as medical insurance to meet basic health needs, accessing mental health services including medication, and establishing a basic financial plan and academic/vocational plans. Secondary goals are establishing program groups, maintaining regular attendance at these groups, and gaining basic skills in the areas of transportation, bill paying, and working with staff, landlords, and roommates.

1. George entered the AB 34 program from the Stanislaus Behavioral Health Center on December 17, 1999. The client has been diagnosed with major depressive disorder, unspecified adjustment disorder with mixed disturbance of emotions and conduct. The client was homeless and had been homeless since August of 1999. Prior to age eighteen, the client was residing in group homes and informal relative settings, as he was unable to maintain residence in his adoptive home. After entering this program, the client was linked to employment within the first two weeks and has maintained that employment ever since. He has received one promotion and his employer is very satisfied with his work performance. He has been hospitalized since entering the program. He struggles a bit with making appointments in the community for needed medical care, and has missed some appointments, but has greatly improved overall and developed very positive rapport with staff.

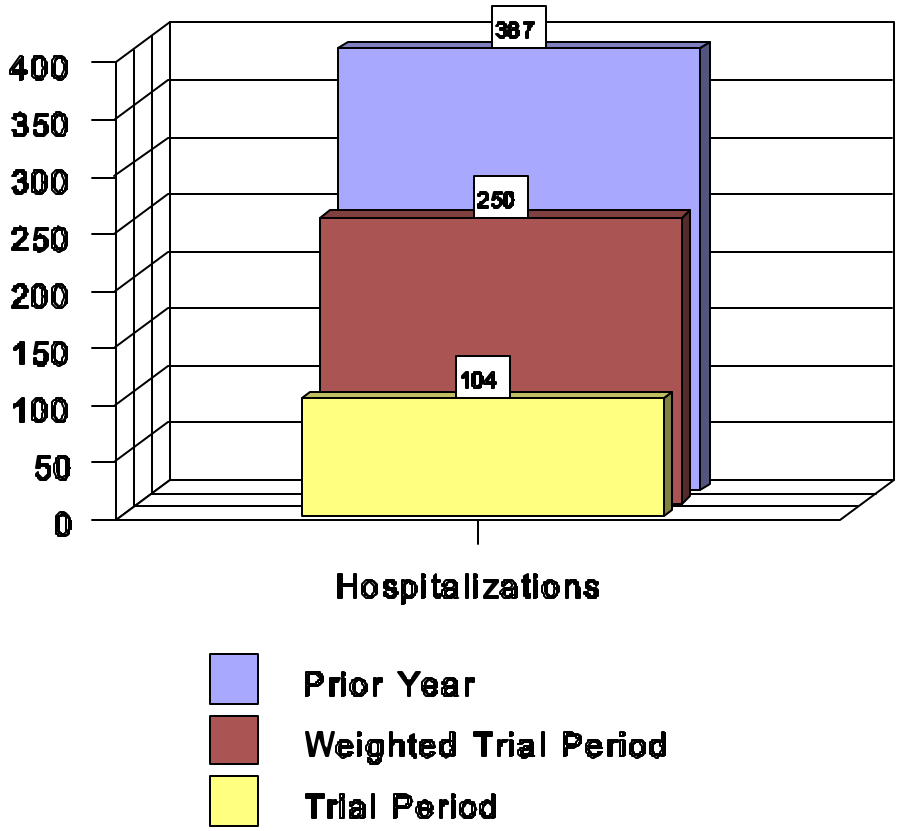
   In addition, Stanislaus County has a program for homeless adults funded through AB 34. The next story is of one of the clients enrolled through the Stanislaus Homeless Outreach Program.

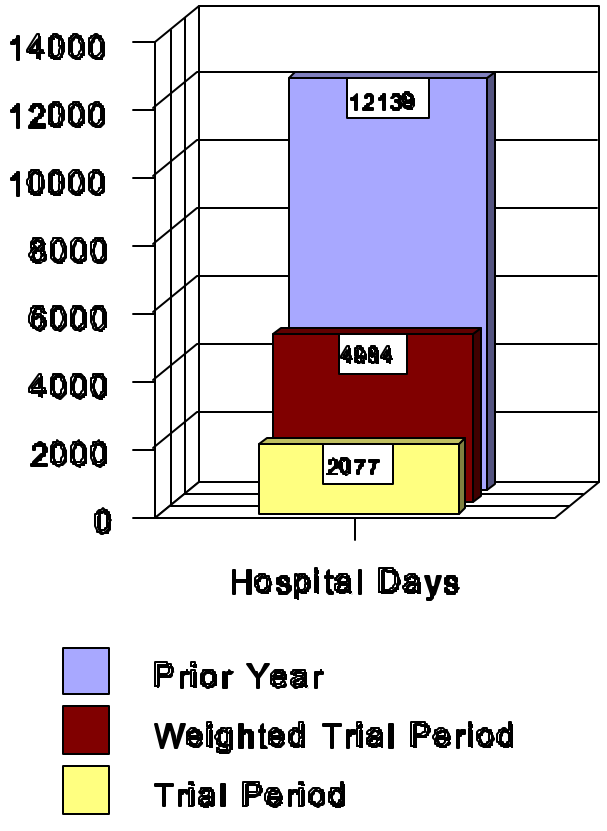
2. Raquel is a 39-year-old Hispanic mother of six children whose ages range from 7 to 17 years of age. One child is autistic. Raquel is diagnosed with major depression. She came to the attention of the program when a social services case manager called asking if they could be of assistance. She was about to be evicted from her home as her social services support was expiring. She had no other resources other than $150 that she

received to help support her autistic son. Thus, the entire family was about to be homeless.

Raquel spoke only Spanish, so the Hispanic bilingual personal services coordinator was assigned to the case. Prior to eviction, the coordinator was able to meet with the landlord, work out a plan to assist the family to remain in housing, and developed a budget to determine what additional needs the family had. The family was put in contact with the food bank and other meal services. Mental health services were also initiated for Raquel and medications were adjusted. Support and encouragement were provided to the 17-year-old daughter who is taking on all of the family burdens as her mother begins her recovery process. The coordinator has also assisted in an individualized education plan for her autistic son, a process both Raquel and her daughter found difficult before the personal services coordinator assisted.

SUCCESSES OF COMMUNITY-BASED PROGRAMS
Hospital Costs





35% fewer hospitalizations

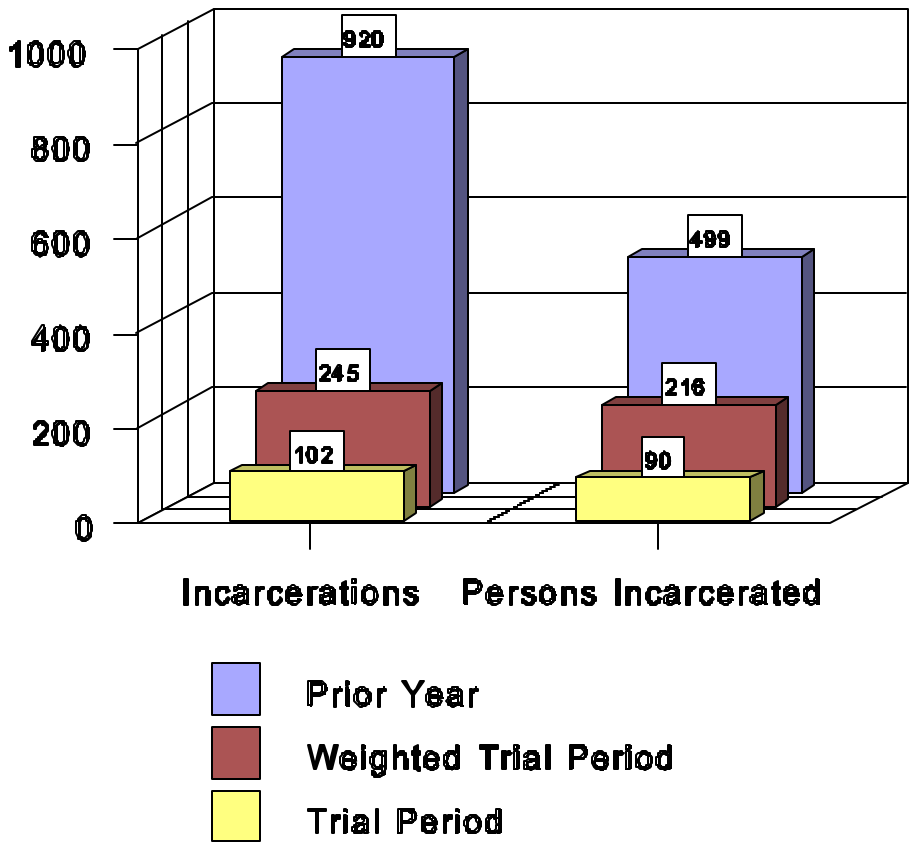
59% fewer hospital days

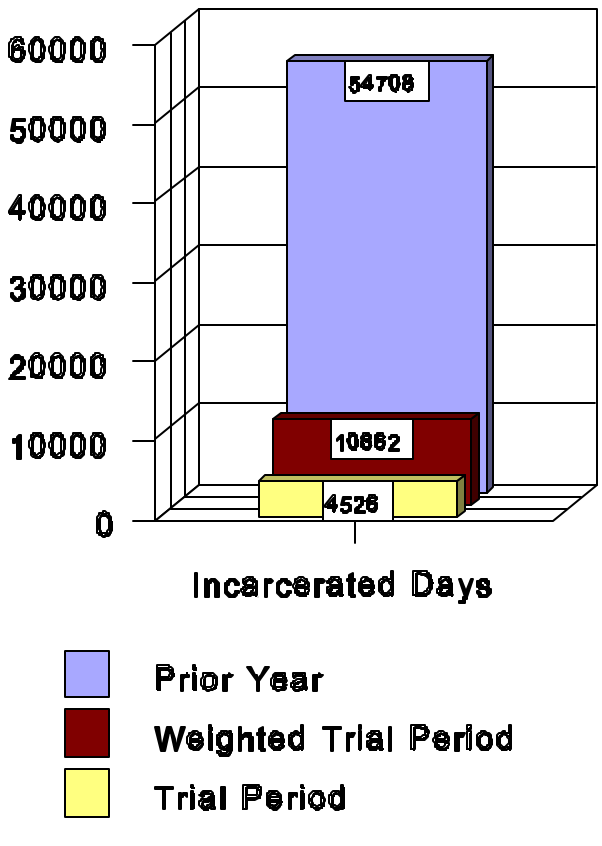
Hospital Cost Savings = $3,219,750

(based upon average cost per day of $450)

SUCCESSES OF COMMUNITY-BASED PROGRAMS

Jail Costs





74% fewer incarcerations

81% fewer jail days

Taxpayer Savings = $17,757,630

(based upon average cost per day of $405)

Appendix 4
Advisory Committee Roster

Roster is attached on the following pages

Appendix 4
AB 34 Advisory Committee Roster
Vince Mandella, Chairperson

Darlene Prettyman, RNC
Government Affairs
The Anne Sippi Clinic
18200 Highway 178
Bakersfield, CA 93306
(661) 871-9697
ASCRANCH@AOL.COM

William J. Crout, Deputy Dir.
Facilities Standards and
Operations Division
600 Bercut Drive
Sacramento, CA 95814
(916) 324-3703
(916) 327-3317 FAX
BOCROUT@BDCORR.CA.GOV

Louie DiNinni, Executive Officer
Board of Prison Terms
428 J Street, 6th Floor
Sacramento, CA 95814
(916) 445-1539
(916) 323-0419 FAX
LDININI@BPT.CA.GOV

(Alternate)
Rick Mandella, Chief
Offender Screening Section
428 J Street, 6th Floor
Sacramento, CA 95814
(916) 323-0949
(916) 323-4804 FAX
Rmandella@bpt.ca.gov

Pearl Johnson LAC/USC
CONT. CARE LINKAGE
1934 Hospital Place Box 132
Los Angeles, CA 90033
(323) 226-5726323)
(323) 226-4310 FAX

Beverly Whitcomb (Alternate)
California Mental Health
Planning Council
1600 9th Street, Room 350
Sacramento, CA 95814
(916) 654-3585
(916) 654-2739 FAX

Victor Montoya, President
California Mental Health Directors
Association
Merced County Mental Health
P. O. Box 839
Merced, CA 95341
(209) 381-6813
(209) 725-8628 FAX

J. R. Elpers, M.D.
California Mental Health
Association
1200 Skyline Blvd.
Woodside, CA 94062
(650) 851-8469
JELPERS@AOL.COM

Larry Poaster, Ph.D., Director
Stanislaus County Mental Health
800 Scenic Drive
Modesto, CA 95350
(209) 525-6225
(209) 558-8233 FAX
Lpoaster@mail.co.stanislaus.ca.us

Rusty Selix, Executive Director
Mental Health Association in
California
CA Council of Community Mental
Health Agencies
1127 11th Street, Suite 830
Sacramento, CA 95814
(916) 557-1166
(916) 447-2350 FAX
ccmha@cwo.com

Sally Zinman, Exec. Director
California Network of Mental Health Clients
1722 J Street, Suite 324
Sacramento, CA 95814
(916) 443-3232
(916) 443-4089 FAX

Elaine Des Roches
2236 Merton Avenue
Los Angeles, CA 90041
(323) 257-4312
(213) 413-1114 FAX
ederoches@excite.com

Margaret Pena
Legislative Representative
California State Association of Counties
1100 K Street, Suite 101
Sacramento, CA 95814
(916) 327-7500, ext. 536
(916) 441-5507 FAX
mpena@counties.org

Carla Javits, Program Director
Corporation for Supportive Housing
1330 Broadway, Suite 601
Oakland, CA 94612
(510) 251-0221
(510) 251-5954 FAX

Carol Wilkins,
Director Health Housing And Integrated Services Network Corporation For Supportive Housing
1330 Broadway Suite 601
Oakland, CA 94612
(510) 251-1910 EXT. 207
(510) 251-5954 FAX
carol.wilkins.@csh.org

Tom Renfree
County Alcohol and Drug Program Administrators Association of California
1029 J Street, Suite 340
Sacramento, CA 95814
(916) 441-1850
(916) 441-6178 FAX

Connie Moreno-Peraza
CADPAAC
800 Scenic Drive
Modesto, CA 95350
(209) 525-7444
(209) 525-6291 FAX

Sally Jantz, Deputy Director
Department of Alcohol and Drug Programs
1700 K Street
Sacramento, CA 95814
(916) 445-1943
(916) 323-5873 FAX

Mr. Cal Terhune, Director
Department of Corrections
1515 S Street, Room 351
Sacramento, CA 95814
(916) 445-7688
(916) 322-2877 FAX

Tim Gage, Director
Department of Finance
State Capitol, Room 1145
Sacramento, CA 95814
(916) 445-4141
(916) 324-7311 FAX

Ms. Kasia O'Neil
Legislative Analyst Office
925 L Street, Suite 1000
Sacramento, CA 95814
(916) 445-6061

Catherine Campisi, Ph.D.,
Director
Department of Rehabilitation
2000 Evergreen
Sacramento, CA 95815
(916) 263-8987
(916) 263-7474 FAX

Darrell Steinberg
Member of the Assembly
State Capitol, Room 2176
Sacramento, CA 95814
(916) 319-2009
(916) 319-2109 FAX

Andrea Jackson,
Chief of Staff
Darrell Steinberg's Office
State Capitol Room 2176
Sacramento, CA 95814
(916) 319-2581
(916) 319-2109 FAX
andrea.jackson@asm.ca.gov

Richard Van Horn, President
Mental Health Association
In Los Angeles
1336 Wilshire Boulevard, 2nd Floor
Los Angeles, CA 90017
(213) 413-1130
(213) 413-1114 FAX
rvanhorn@mhala.org

Sheriff Lou Blanas
Sacramento County Sheriff's
Department
711 G Street, Room 401
Sacramento, CA 95814
(916) 874-7146
(916) 874-5332 FAX

(Send to) Gordon Crowder
711 G Street, Room 401
Sacramento, CA 95814
(916) 874-7166
(916) 874-5336
Gcrowder@SaSheriff.Com

Phil Murphy
Sacramento County Sheriff's
Department
711 G Street
Sacramento, CA 95814

Commander Taylor Moorehead
Los Angeles County
Sheriff's Department
450 Bauchet Street, Room 815
Los Angeles, CA 90012
(213) 893-5884
TKMooreH@Lasd.org

(Send all written materials to)
Deputy Vicki Rice
Los Angeles County Sheriff's Dept.
450 Bauchet Street, Room 815
Los Angeles, CA 90012
(213) 893-5108
(213) 613-4780 FAX
VSRice@LASD.ORG

Stephani Hardy
Acting Executive Director
Los Angeles Veterans Initiative, Inc.
Westside Residence Hall
733 South Hindry Avenue
Inglewood, CA 90301
(310) 348-7600
(310) 641-2661 FAX

Jeff Wilkins, M.D.
Director of Research
U. S. Veterans Initiative, Inc.
733 S. Hindry Avenue
Inglewood, CA 90301
(310) 348-7600 ext. 3133
(310) 641-2661 FAX
JWilkins@UCLA.edu

Tom Farris
NAMI California
1621 La Loma Avenue
Berkeley, CA 94709-11015
(510) 845-8545
(510) 845-8545
tofarris@earthlink.net

William L. Daniels, MSW
Director, Health Care Center
11301 Wilshire Blvd.
Los Angeles, CA 90073
(310) 268-3385
(310) 268-4946 FAX

NAMI California
ATTN: Grace McAndrews
1111 Howe Avenue, Suite 475
Sacramento, CA 95825
(916) 567-0163
(916) 567-1757 FAX